

*Privatization of Health Care*

**THE COLOMBIAN HEALTH INSURANCE  
SYSTEM AND ITS EFFECT ON ACCESS  
TO HEALTH CARE**

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In 1993, the Colombian government sought to reform its health care system under the guidance of international financial institutions (the World Bank and International Monetary Fund). These institutions maintain that individual private health insurance systems are more appropriate than previously established national public health structures for overcoming inequities in health care in developing countries. The reforms carried out following international financial institution guidelines are known as “neoliberal reforms.” This qualitative study explores consumer health choices and associated factors, based on interviews with citizens living in Medellín, Colombia, in 2005–2006. The results show that most study participants belonging to low-income and middle-income strata, even with medical expense subsidies, faced significant barriers to accessing health care. Only upper-income participants reported a selection of different options without barriers, such as complementary and alternative medicines, along with private Western biomedicine. This study is unique in that the informal health system is linked to overall neoliberal policy change.

The reform to Colombia’s health care system was presented as the “solution” to the crisis of its health sector (1). During the late 1980s, the Colombian health system had experienced difficulties in continuing the improvements in health indicators that had been occurring since the early 20th century, and especially since 1940. Likewise, Colombia faced some limitations in resolving challenges such as increased inequalities in health services, growth in the population without health care coverage, and maldistribution in underserved rural and urban zones

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(2). Many other Latin American countries shared similar weaknesses. During the late 1980s and early 1990s, these weaknesses began to be referred to as the “crisis of the Latin American health sector” (3–5). The official assessment of the health crisis in Colombia included: the costs of the sector, the excessive power of physicians, and the inefficiency of state interventions. This assessment quickly became commonplace in the great majority of writings by health policy analysts of different ideological positions, many pertaining to the economic scope of the problem (3–5).

In this context, the World Bank and International Monetary Fund put forward policies that liberalized markets through deregulation, privatization, and downsizing of the government’s role. This group of reforms applied to Latin American health care systems came to be known as “neoliberal health reforms” (3, 6, 7). The *neoliberal health model* borrowed from the policy directions in North America, ignoring actual results in terms of costs, decreasing insurance coverage, and social inequities (8–15). In fact, international financial institutions and a variety of academics promulgated the U.S. model as desirable for all nations despite the evidence of its failings when confronting impoverishment, rising social epidemics, and a host of “neglected diseases” across the southern hemisphere (16, 17). In Colombia, the neoliberal health reform was implemented through Law 100, passed in 1993. The reform consisted essentially of the following elements (18).

1. *Privatization of the care delivery system.* The public hospitals and health centers in urban and rural zones became private institutions, no longer directed by the public health planning function of the health ministry. They no longer receive funds from the state at either the national or municipal level. As in the United States, such an uneven playing field (with respect to health workers’ salary levels, quality of facilities, availability of technology, location, etc.) created severe hardship for providers that, historically and geographically, have borne the brunt of care for the country’s poorer, sicker population groups (19).

2. *Individual health insurance as the mechanism for receiving health care.* There are two branches: a *contributive system* and a *subsidized system*, run by private health insurance companies (Table 1).

3. *Development of a basic benefit plan*, including medical procedures, hospitalizations, and medicines that insurance companies must guarantee to their enrollees. As with all benefit packages designed for cost containment, medical procedures and medicines not included in the plans have to be bought out-of-pocket on the private market.

4. *Public health no longer a coordinated group of programs provided by government institutions, but commodified into a series of individual programs*, such as vaccinations or health education sessions, which health insurance companies provide individually to their members. No longer are there targeted groups for community health interventions, so necessary for addressing a variety of health conditions that plague poorer population groups.

Table 1

## Health insurance system in Colombia

Insurance scheme	Who is covered	Payment
Contributive system: Empresas Promotoras de Salud (EPS)	Employees, employers, and persons who can afford to purchase	Employee pays 25% of premium
Subsidized system: Administradoras de Regimen Subsidiado (ARS)	Those who cannot afford the contributive system (people in poverty and low income)	States assume costs of 90%, 70%, or 30% of medical expenses, depending on income

*Source:* Government of Colombia (18).

Since the reform, most of the information promulgated by government institutions points out that the Colombian health system is now successful due to the increasing coverage under the subsidized system (Administradoras de Regimen Subsidiado, or ARS), which increased from 22.5 percent of the population in 2000 to 34.0 percent in 2004 and 49.2 percent in 2007 (20). In turn, the contributive system (Empresas Promotoras de Salud, or EPS) covered about 34 percent of the population in 2007, with no substantial increase in coverage since 2000. According to government data, the proportion of population uninsured in 2007 was 12 percent (20).

In studies carried out in Antioquia (the state of which Medellín is the capital), people enrolled in the subsidized system reported that lack of money is the main reason not to seek a health care provider when needed. Likewise, these people have a greater probability of having a bad self-reported health status compared with people enrolled in the contributive system (21).

Confusion over the effects of neoliberal policy led to our research on the Colombian reforms. The purpose of this qualitative study is to explore consumer health choices among 46 study participants living in Medellín. "Health choices" refer to the steps and decisions people take in order to treat their illnesses and become healthier. Particular attention was paid to the effects on actual access to care of people's health choices as constrained by the new policy initiative.

## METHODS

The research design of this qualitative study used sampling strategies, data collection, and data analysis based on the premises shared by most qualitative methodologies, especially those from grounded theory (22, 23) and rapid assessment procedures (24, 25). Some specific techniques were taken from Miles and

Huberman's guidelines for qualitative studies (26). Both methodologies—grounded theory and rapid assessment procedures—were considered appropriate, given that the study's goal was to build a theory grounded in the perspective of participants' health-seeking behavior during a short interval of time.

The study participants were 46 Colombians from differing social classes in Medellín. This is a city with huge numbers of people streaming in from the impoverished countryside; its population growth presents dramatic contrasts along with formidable social challenges, such as unemployment, drug trafficking, and armed illegal groups, both pro- and anti-establishment.

The population of Medellín is grouped into six socioeconomic strata, with stratum 1 the poorest and stratum 6 the richest. Strata are classified along eight variables related to external housing characteristics and immediate surroundings. "External housing characteristics" refer to materials used for construction, number of floors, total area, garage, and garden. "Surroundings" refer to avenues, parks, large stores, public spaces, and public utilities available in the area. Surroundings variables are weighted more than housing characteristics. As a consequence, all housing located in the same sector belongs to the same socioeconomic stratum. Strata are the basis for public utility payments, property taxes, and public university tuition (27).

Criteria for inclusion in the study sample were (a) all participants were in the age range of 30 to 60 years old; and (b) all participants were able to read and write in Spanish. Fifty percent were women, 50 percent were men. The 30- to 60-year-old age range was selected because this age group seeks health care more frequently than those under 30. It is also more likely that this group would provide data about family health-seeking behaviors. Exclusion criteria were (a) no participants were health care professors, practitioners, or students; and (b) no pregnant women were included. Widespread prenatal programs exist in Colombia, especially in its largest cities, so pregnant women are assumed to use health services more intensely than the rest of the population.

Twenty-two participants belonged to socioeconomic strata 1 and 2; 12 to strata 3 and 4; and 12 to strata 5 and 6. Participants in strata 1 to 4 were contacted through key informants who are neighborhood community organization leaders. Participants in strata 5 and 6 were contacted through key informants working in public and private companies. Participants were asked for their informed consent, with the research protocol approved by the Offices for Protection of Research Subjects of the University of Illinois at Chicago and the Universidad de Antioquia in Medellín–Colombia.

Data collection utilized semi-structured interviews, loosely structured with open-ended questions (28); the starting point inquired whether the person had felt sick at any time during the past three months. The open-ended question approach encouraged interviewees to narrate steps they had taken to seek health resources on their own terms, from their point of view. Interviews were recorded on audiotapes.

## RESULTS

Since the socioeconomic stratum to which people belong generates differences in seeking health resources and available alternatives, results are presented according to participants' socioeconomic stratum. Results for uninsured persons belonging to different strata are presented later.

Courses of action taken by persons in socioeconomic strata 1 and 2 were, in order of preference: self-medication, pharmacists, medicinal plants (homemade remedies), leaving the problem unsolved, and, finally, seeking a physician assigned by their health insurance company (Figure 1).

Self-medication is understood as a decision made by the individual to consume over-the-counter (OTC) medicines developed by pharmaceutical laboratories,

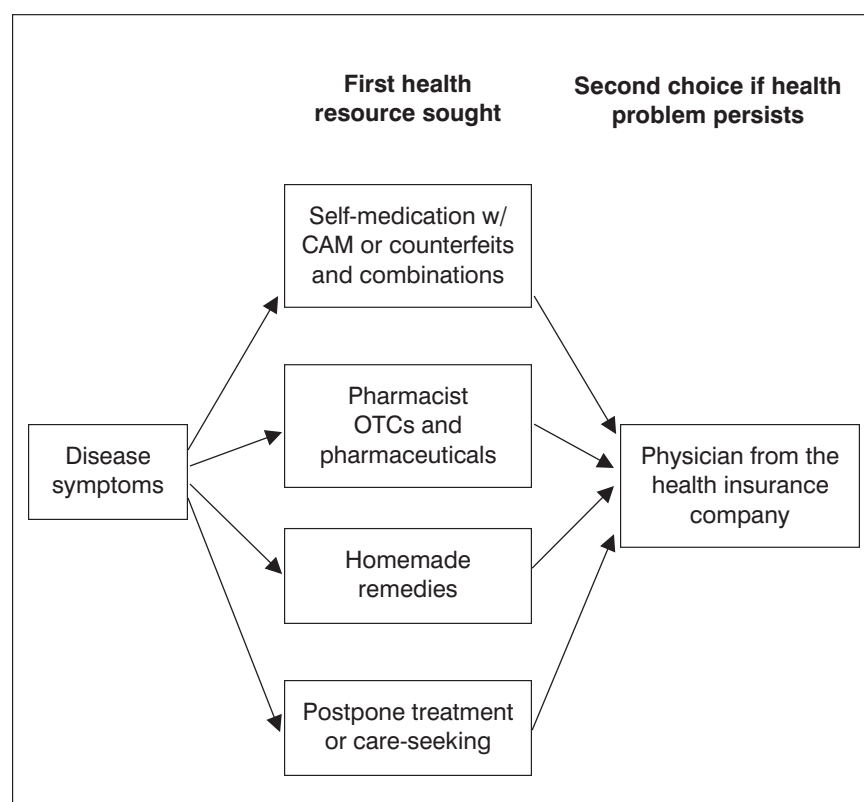


Figure 1. Health-seeking behaviors of persons in socioeconomic strata 1 and 2 (low income), Colombia: first step, and decisions made if the health problem persists. *Note:* CAM, complementary and alternative medicine; OTCs, over-the-counter medicines.

without advice from a health professional. It is important to highlight that in the case of persons in socioeconomic strata 1 and 2, decisions on what medications to consume (pills or injections) are made by the sick person after receiving advice from friends, relatives, or neighbors, none of whom are educated in the health care field. Self-medication was described by those interviewees who had a medical expense subsidy at any of the three levels: 90, 70, or 30 percent.

In Colombia, pharmaceuticals can be purchased on the open market without prescribing by a licensed health care practitioner, in a pharmacy or from counterfeit sellers. An aspect that is important to emphasize here is that in many cases, people in socioeconomic strata 1 and 2 combine pharmaceutical drugs with medicinal plants or homemade beverages, and refer to these as homemade remedies. For example, they mix hot cane water (*aguapanela*) with lemon and available antibiotics to cure flu and cough.

The second resource commonly sought by people in strata 1 and 2 is a pharmacy seller. Pharmacies in Colombia can be grouped into two categories: (a) those located in big chain retail stores, such as Carrefour and ÉXITO; and (b) small private pharmacies located in poor neighborhoods that sell any type of drug without a professional's prescription, and sometimes counterfeit medicines made by illegal laboratories. In the first category, regulations about sellers' training (in accredited colleges) and requirements about prescriptions ordered by physicians are usually followed. People may talk to a pharmacist or pick up OTC items from the aisles. On the contrary, most small pharmacy owners have no formal education in the health care field. Seeking the advice of a pharmacy seller with no formal education and buying the medicine he or she suggests is a common practice for people in socioeconomic strata 1 and 2, including those affiliated with the subsidized system (who have a health expense subsidy). This practice is uncommon among people in strata 3 to 6. According to the Ministry of Health, regulations say that pharmacy sellers are not authorized to prescribe medicines, but that rule is constantly violated.

Use of medicinal plants is also one of the more commonly sought resources by people in the poorer socioeconomic strata. Interviewees said they cultivated these plants in their yards. In addition, there is an exchange of knowledge about plants among neighbors, as mentioned by one interviewee: "My mother-in-law made us a home remedy with a little lemon plant to cure flu. She consulted one of our neighbors who she knew had it in her yard. She asked her neighbor for some, and then she returned with a lot to make the beverage for all of us" (woman in stratum 1).

Related to the factors that determine people's health choices, interviewees in socioeconomic strata 1 and 2 said that their decisions were influenced especially by financial barriers, due to their low income. In Medellín, people in strata 1 and 2 have a family income of, on average, US\$4 a day, and the minimal food basket for a family costs US\$5 a day (29). This means that many people have wages just sufficient to buy food, implying that other basic needs go unmet.

Interviewees in strata 1 and 2 also said that sometimes the transportation costs are so high that they delay or give up seeking care. Medellín lies in a valley located between two high mountains. The downtown area (where most health institutions are located) is in the flat part of the valley, while poor neighborhoods (strata 1 and 2) are way up in the mountains. Although the distance in miles may not be far, for the poorest people the distance in time, with geographic barriers due to the irregular topography, may hinder easy access to health care. So transportation costs are a significant barrier that puts people's lives at risk, especially in cases of an emergency. In Colombia, there are no public emergency services to get people to a health institution. Ambulance services are private and exclusive to prepaid medical policies. When individuals feel the need to go to an emergency room and do not have a prepaid medical policy, they have to get there by their own means. The rate of car ownership among low-income people in Colombia is 1.5 percent (30). A summary of costs for seeking care is given in Table 2.

The third barrier, after co-payments and transportation costs, that limits access to health services is related to the schedules and administrative mechanisms of health care institutions. In the subsidized system, patients have to go to the health center at 5 o'clock in the morning and wait for an appointment to be assigned. Centers generally assign just 15 appointments per day, so not everyone will be seen.

Sometimes barriers imposed by the lack of money for transportation and co-payments surpass the reality of how severe a person's illness actually is. Although individuals feel, or in fact clearly know, that they have or may have a severe illness, costs and/or administrative barriers take root to limit access critical for treatment.

Interviewees in socioeconomic stratum 3 and higher had health choice patterns that differed from those of the poor. In strata 3 and 4 (middle-income people), the most sought health resources were doctors who practice Western biomedicine.

Table 2

Administradoras de Regimen Subsidiado (ARS): costs for physician care,  
U.S. dollars, Medellín, 2006

Subsidy amount	Patient payment	Roundtrip ticket transportation	Total cost to seek care
90%	\$0.35	\$1.00	\$1.35
70%	\$0.65	\$1.00	\$1.65
30%	\$1.20	\$1.00	\$2.20

Sources: Interviewees and Alcaldía de Medellín, [www.medellin.gov.co](http://www.medellin.gov.co).

The health insurance companies in their networks assign these doctors. Most interviewees in strata 3 and 4 were enrolled in the contributive system, because they were employed, paid on their own, or were a family beneficiary. Related to factors influencing health choices, although most interviewees in strata 3 and 4 were in the contributive system, they also described facing barriers to accessing health services—but these barriers differ from those for poorer persons. In strata 3 and 4, barriers were administrative, generally being obstacles imposed by the EPS to discourage use of services. These obstacles are related to schedules, waiting times for appointments, and approved reasons for consultations.

Administrative barriers constitute an important reason for some people in strata 3 and 4 to decide not to seek care. In those cases, most opt for self-medication and homemade remedies (Figure 2). However, to be clear, people who feel their ailments are serious but who face barriers to care are forced to resolve their problems by seeking resources paid for out-of-pocket, even though these are added costs.

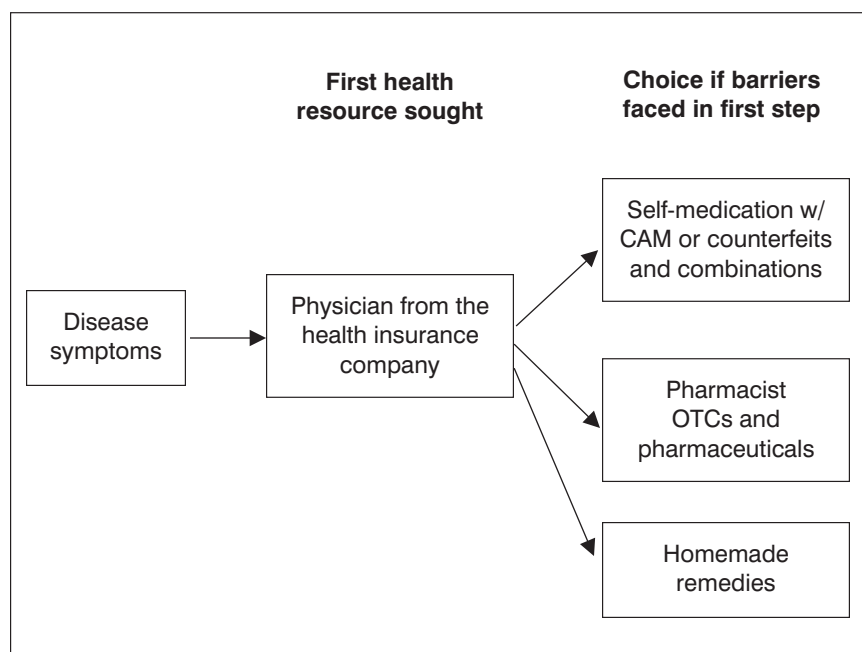


Figure 2. Health-seeking behaviors of persons in socioeconomic strata 3 and 4 (middle income), Colombia: first step, and decisions made as administrative barriers are faced. *Note:* CAM, complementary and alternative medicine; OTCs, over-the-counter medicines.

For interviewees in socioeconomic strata 5 and 6 (high income), the most commonly sought resource was Western biomedicine physicians. The difference from those in strata 3 and 4 is that for the higher strata, a Western biomedicine doctor is generally chosen from a prepaid medical plan (a professional who conducts his or her practice in private medicine), a relative, or in a few cases, a practitioner assigned by their health insurance company.

#### *Health Resources Sought by People without Health Insurance*

Persons in all social strata who are not enrolled in the contributive or subsidized systems (that is, the uninsured) face a special situation. In this study, uninsured interviewees in strata 1, 3, and 4 were unemployed or were working in the informal economy without sufficient resources to afford private health insurance premiums. Uninsured individuals in strata 3 and 4 (some of whom were professionals) had the same behavior pattern as those with no health insurance in stratum 1 and those with health insurance but who cannot afford the co-payments and transportation. All people without insurance (regardless of their strata) self-medicate, use homemade remedies, or seek a pharmacy seller, even when they consider their illnesses serious or potentially serious.

#### *Opinions on the Current Health System*

While this study did not aim to assess the current health care system, interviewees were asked about their perceptions of both the overall system and the system (EPS or ARS) in which they were enrolled, if any. People in strata 5 and 6 offered criticisms of the Colombian health system because they believed it excludes many people who do not have health insurance. They also stated that the “reformed” Colombian system is more expensive, with their having to pay for prepaid medical plans in order to access adequate health services.

On the other hand, people in strata 1 and 2 tended to support the current policy, especially the subsidized system. They stated that this government program has given them an insurance card to access care. Even though they recognized that it does not include comprehensive health care, most believed that, otherwise, they might have been completely excluded.

The national government has strongly campaigned on insurance cards entitling people to request “health rights,” so people apparently feel less vulnerable. However, the national authority in charge of surveillance of quality of care (Superintendencia Nacional de Salud) states that “people belonging to the Subsidized Regime do not claim to the Health Insurance Companies (ARS) because they consider that the health care services they receive are for charity. They are profoundly thankful” (31).

## DISCUSSION

Neoliberal health reforms in Colombia have had several consequences for health care access, as this study reveals. The most relevant factors in decisions made by poorer people (socioeconomic strata 1 and 2) about seeking health services are financial barriers (such as co-payments and costs of transportation) and administrative barriers (such as schedules and procedures imposed by health institutions). People in strata 3 and 4 also face administrative barriers to accessing services. For that reason, they sometimes abstain from using services, but mostly they end up seeking resources in private medicine, paying out-of-pocket fees.

That people with subsidized health insurance do not have improved access to services constitutes a double problem: the poorest people are putting off treatment for their illnesses by ignoring them, and as a consequence, part of the social health expenditure is being inefficiently invested. Colombian society is dedicating a considerable amount of its gross domestic product (GDP) to pay the private health insurance companies of the subsidized system (ARS) for services that people are not using properly, or not using at all. The national government pays a monthly premium to these private companies for each enrolled person, regardless of their utilization. The total social expenditure increased from 9.3 to 18.4 percent of GDP from 1990 to 2007, due in part to the 1993 reform (32). Furthermore, with the health care system based on individual private insurance, many of Colombia's poor are forced to use therapeutic alternatives that may be medically ineffective and/or dangerous to their well-being.

The results of our study agree with research carried out in seven Latin American countries (including Colombia) (33), which concluded that 44 percent of Colombians buy medications with a medical prescription, while most (56%) self-medicate by acquiring medicines without prescription. This highlights the fact that the private health insurance scheme does not resolve the problem of self-medication by poor people; they continue to pay disproportionately for medications out-of-pocket. The black market of counterfeit drugs also remains an insurmountable problem in Latin America. The untoward mixing of folk and herbal medicines with Western agents can lead to many clinical mishaps, amid a general failure to secure early access to proven modern therapies (generic or brand-name). This then leads to further downstream utilization, needless suffering, disability, and premature death. The implications for economic and social development should be clear. Pharmaceutical expenditures also climb, given the general ineffectiveness resulting from lack of proper, professional pharmaceutical care (34–40).

Multinational drug corporations have beefed up their marketing worldwide, targeting emerging economies to authorize their patented products, particularly in the wake of proliferating privatization schemes urged by international financial institutions. For example, Homedes and colleagues (41) reported that Peru in the late 1980s registered about 80 drugs per year, but in the 1990s the

number averaged more than 1,000 annually, with one year recording 2,000 products. These are mostly brand-name drugs from Western multinational pharmaceutical firms.

In any country, poor people already spend disproportionately more on pharmaceuticals from their meager incomes, and certain brand-name drugs from the North are often beyond the reach of even the middle classes in the wealthier, developed nations, let alone people with lower incomes in Latin America, Asia, and Africa.

What we can conclude from this study is that the only social groups that do not seem to confront an access problem are those in socioeconomic strata 5 and 6 (high income). While this seems to be due to their private prepaid medical policies, it also demonstrates the social inefficiency in Colombia's private health insurance system. People who acquire a prepaid medical policy actually pay twice: first they must be enrolled in the contributive system (which is mandatory for every employee) and are required to pay that premium, then they pay for the prepaid medical policy. The difference between the two is that prepaid medical plans offer medical procedures not included in the basic plan in the contributive system. The prepaid plans also offer more comfortable services, such as expedited appointments and private rooms during hospitalizations.

A study by the Colombian Ministry of Health in 1991, as well as other studies carried out during the late 1980s, demonstrated that a lack of financial resources was the most important barrier to accessing health services (42). When the neoliberal reform was implemented in 1993, it was stated that the new health insurance would diminish inequities by increasing access, especially for the poorest. The propaganda was that individual private insurance is more effective than the old national public health system, and that it diminishes the barrier that historically has impeded access for the poorest—that is to say, their lack of money. Supposedly, once people were holders of a health insurance card sponsored by a private company, the delivery institutions would be more willing to meet their care needs. And having the insurance card would eradicate many of the cultural barriers that intimidated people with low incomes or low education levels when seeking care.

As our study found, the situation in Colombia is totally different from the theory proffered by supporters of neoliberal reform. Even though low-income people are entitled to individual insurance, it does not represent improved access to care, but instead results in much less attention to their health needs. Thus, while the theory of neoliberal reform might avow greater access to care for the poorest citizens, this has not been realized in the new social reality of Colombia.

A finding from our research that deserves deeper analysis is that shifting national health expenditures toward the very-low-income groups to subsidize their medical expenses seems to have provoked a new, more complex social phenomenon. People receiving government subsidy for their health expenses—even though they continue to face access barriers—are politically supporting the 1993

reform, particularly its subsidized system. This seems to be because, in theory, the system is providing them with “rights” they have never had before: receipt of an insurance card. This would seem to indicate that the new health policy actually legitimizes a new social order: the neoliberal order for Latin America. Such legitimacy is based on improving *apparent* access to health services for the very-low-income population, but diminishing access and other rights for the working and middle classes.

The new neoliberal policies do not imply that all low-income people are totally integrated into society. It is only a functional recognition to make some people *feel* integrated through a social policy adjustment, even though their socioeconomic conditions, as well as their relative political power, remain the same (43). A stated aim of the neoliberal social policy is to fight poverty; but it does not aim to overcome inequality or reduce the exclusion suffered by low-income people. Yet it seeks to alleviate the most visible effects that derive from the neoliberal model’s application (44).

The neoliberal reformers have been smart enough to conceal their reliance on government for subsidizing their private enterprise “solutions” to social problems. Yet, in fact, this group of advocates seeks to redistribute income upward to higher-paid workers, business owners, investors, and often multinational corporate compatriots with whom they form alliances. When one surveys Latin American national health systems through a business lens, it is clear that opportunities abound for the setting up of a new medical-industrial complex beholden to U.S. and European capital in the form of insurance, pharmaceutical, hospital equipment and supply, construction, computer, accountancy, legal, management consultancy, and proprietary provider firms. Privatization schemes lay the groundwork for a shift to importing “U.S. know-how” for running an “advanced” and “modern” health care enterprise.

Neoliberal reforms, however, have been shown to fail not only the poor but other national income groups as well, who also face ongoing barriers to accessing care. The privatization comes in opposition to the strengthening of public health services that have been systematically neglected over decades. Moreover, there is a general absence of regulation of the worst excesses of the private health sector. This was the essence of the research in the Affordability Ladder Program Studies, many published in the *International Journal of Health Services* (45). These studies found it difficult to explore the use of the informal health sector, however. Our study in Colombia, reported here, does help us understand the impact of self-care, alternative therapies, and other informal care related to the imposition of neoliberal health policies. McIntyre and colleagues noted that the growth of informal providers has “profound implications for the adequacy of self-treatment or other forms of informal care” (45, p. 695).

Throughout Latin America, neoliberal policies have failed in terms of holding down the growth in expenditures, reducing the absolute number of people in poverty, and decreasing social inequality. There was a remarkable deterioration of social indicators over the 1980s, followed by some recovery in the 1990s, but the social situation continues to be fragile and critical, as measured by poverty levels and social exclusion (20).

Finally, all aspects of the Colombian reform described here demand further study to facilitate true reform strategies under conditions of dependency. This research was an initial exploration of the health choices of Medellín's inhabitants. In Colombia, there have been no qualitative studies on health care access from the perspective of the users of health care; additional exploration may uncover added dimensions and provide analysis for more fully designing remedial strategies. A quantitative analysis could determine how many people are facing access barriers, the specific types of barriers they face depending on their insurance system, and perhaps what strategies they employ to overcome such barriers. The latter may necessitate policies to assist people with overcoming unhealthy conditions. Here, studies of more progressive societies in Latin America could yield greater cross-cultural insights.

Today, critical studies to advance the purpose of public health are vital to formulating progressive policy change. A social agenda for investigations that rely on popular experience can often illuminate how best to serve a population's true health and health care needs.

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